		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028696

Facility Name: BIRCHWOOD PLAZA

Address: 1426 W BIRCHWOOD (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 274-4405 **Fax #** (773) 274-4763

IDPA ID Number: 36-330652201

Date of Initial License for Current Owners: 06/17/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) CHARLOTTE KOHN
(Title) EXECUTIVE DIRECTOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	192	Skilled (SNF)	192	70,080	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	192	TOTALS	192	70,080	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	38,258	8,201	1,668	48,127	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,258	8,201	1,668	48,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.67%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/17/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/17/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 1,668

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	183,202	23,059	8,728	214,989		214,989		214,989			1
2	Food Purchase		179,585		179,585	(16,352)	163,233	(872)	162,361			2
3	Housekeeping	148,734	34,029		182,763		182,763		182,763			3
4	Laundry	32,657	11,673	778	45,108		45,108		45,108			4
5	Heat and Other Utilities			94,276	94,276		94,276		94,276			5
6	Maintenance	59,321	13,681	23,143	96,145		96,145	4,718	100,863			6
7	Other (specify):*			4,920	4,920		4,920		4,920			7
8	**TOTAL General Services**	423,914	262,027	131,845	817,786	(16,352)	801,434	3,846	805,280			8
	B. Health Care and Programs											
9	Medical Director			6,500	6,500		6,500		6,500			9
10	Nursing and Medical Records	1,527,211	57,742	19,080	1,604,033		1,604,033		1,604,033			10
10a	Therapy	48,523		45,892	94,415		94,415		94,415			10a
11	Activities	112,117	12,334	4,796	129,247		129,247		129,247			11
12	Social Services	53,225		2,860	56,085		56,085		56,085			12
13	Nurse Aide Training			3,335	3,335		3,335		3,335			13
14	Program Transportation			75	75		75		75			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,741,076	70,076	82,538	1,893,690		1,893,690		1,893,690			16
	C. General Administration											
17	Administrative	241,533		329,277	570,810		570,810		570,810			17
18	Directors Fees											18
19	Professional Services			55,021	55,021		55,021		55,021			19
20	Dues, Fees, Subscriptions & Promotions			86,052	86,052		86,052	(75,271)	10,781			20
21	Clerical & General Office Expenses	101,282	8,814	38,801	148,897		148,897	(3,600)	145,297			21
22	Employee Benefits & Payroll Taxes			344,094	344,094	16,352	360,446		360,446			22
23	Inservice Training & Education			1,117	1,117		1,117		1,117			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			2,942	2,942		2,942		2,942			25
26	Insurance-Prop.Liab.Malpractice			358,489	358,489		358,489		358,489			26
27	Other (specify):*											27
28	**TOTAL General Administration**	342,815	8,814	1,215,793	1,567,422	16,352	1,583,774	(78,871)	1,504,903			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,507,805	340,917	1,430,176	4,278,898		4,278,898	(75,025)	4,203,873			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BIRCHWOOD PLAZA #0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation							135,825	135,825			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,389	16,389		16,389	41,532	57,921			32
33	Real Estate Taxes			172,826	172,826		172,826		172,826			33
34	Rent-Facility & Grounds			420,480	420,480		420,480	(420,480)				34
35	Rent-Equipment & Vehicles			18,098	18,098		18,098		18,098			35
36	Other (specify):*											36
37	**TOTAL Ownership**			627,793	627,793		627,793	(243,123)	384,670			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		64,958	29,245	94,203		94,203		94,203			39
40	Barber and Beauty Shops			8,033	8,033		8,033		8,033			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,880	107,880		107,880		107,880			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		64,958	145,158	210,116		210,116		210,116			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,507,805	405,875	2,203,127	5,116,807		5,116,807	(318,148)	4,798,659			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(872)	2		13
14	Non-Care Related Interest	(35)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(50)	20		17
18	Fines and Penalties	(3,680)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,692)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(56,529)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	4,718	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (75,140)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(243,008)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (243,008)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (318,148)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BIRCHWOOD PLAZA

ID# 0028696

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 4,718	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	4,718		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(872)	0	0	0	0	0	0	0	0	0	0	(872)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	4,718	0	0	0	0	0	0	0	0	0	0	4,718	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	3,846	0	0	0	0	0	0	0	0	0	0	3,846	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(75,271)	0	0	0	0	0	0	0	0	0	0	(75,271)	20
21	Clerical & General Office Expenses	(3,680)	80	0	0	0	0	0	0	0	0	0	(3,600)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(78,951)	80	0	0	0	0	0	0	0	0	0	(78,871)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(75,105)	80	0	0	0	0	0	0	0	0	0	(75,025)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number BIRCHWOOD PLAZA **#** 0028696 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	135,825	0	0	0	0	0	0	0	0	0	135,825	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(35)	41,567	0	0	0	0	0	0	0	0	0	41,532	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(420,480)	0	0	0	0	0	0	0	0	0	(420,480)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(35)	(243,088)	0	0	0	0	0	0	0	0	0	(243,123)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(75,140)	(243,008)	0	0	0	0	0	0	0	0	0	(318,148)	45

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
CHARLOTTE KOHN	55.7	DOBSON PLAZA INC	EVANSTON	BIRCHWOOD PLAZA ASSOCIATES		REAL ESTATE
		PEDIATRIC REHABILITATION INSTITUTE	CHICAGO		CHICAGO	RENTAL

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 420,480	BIRCHWOOD PLAZA ASSOCIATES		$	$ (420,480)	1
2	V	30	SL DEPRECIATION		" "		135,825	135,825	2
3	V	32	INTEREST		" "		41,567	41,567	3
4	V	21	OFFICE EXPENSE		" "		80	80	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 420,480			$ 177,472	$ * (243,008)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CHARLOTTE KOHN	PRESIDENT	EXEC DIR.	100.00	365,572	30	40.00	MGMT FEES	$ 329,277	17-3	1
2	RAMONA WEINGARTEN	DAUGHTER	ACTIVITIES		0	40	100.00	SALARY	29,679	11-1	2
3											3
4											4
5											5
6											6
7	BY ATTRIBUTION 100% KOHN FAMILY OWNED										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 358,956		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - BIRCHWOOD PLAZA ASSOCIATES:						$	$			$	1
2	MID-NORTH FINANCIAL		X	MORTGAGE	$46,440.00	1/6/1994	2,000,000	273,641	1/04	7.5000	30,957	2
3	TITLE & LOAN FEES		X	AMORTIZED OVER 10 YRS			106,103	8,925			10,610	3
4												4
5												5
	Working Capital											
6	ABRAHAM SCHIFFMAN	X		INSUR. FINANCE	$17,258.92	7/01	207,107		7/02		13,462	6
7	ABRAHAM SCHIFFMAN	X		INSUR. FINANCE	$8,919.88	7/02	103,501	61,158	7/03	6.2500	2,257	7
8	ABRAHAM SCHIFFMAN	X		INSUR. FINANCE	$11,902.90	12/02	138,669	127,402	12/03	5.5000	635	8
9	TOTAL Facility Related				$84,521.70		$ 2,555,380	$ 471,126			$ 57,921	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES							35	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 35	14
15	TOTALS (line 9+line14)						$ 2,555,380	$ 471,126			$ 57,956	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 165,890	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 168,516	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,626	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 170,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 172,826	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	190,211	8
	1998	193,588	9
	1999	192,289	10
	2000	164,244	11
	2001	168,516	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIRCHWOOD PLAZA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0028696

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-302-011-0000	NURSING HOME	$ 2,915.19	$ 2,915.19
2.	11-29-302-012-0000	NURSING HOME	$ 73,514.98	$ 73,514.98
3.	11-29-302-020-0000	NURSING HOME	$ 92,085.55	$ 92,085.55
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 168,515.72	$ 168,515.72

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame STEEL & CONCRET Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RELATED PARTY: BIRCHWOOD PLAZA ASSOC			$	1
2	NURSING HOME		1984	80,569	2
3	TOTALS			$ 80,569	3

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: BIRCHWOOD PLAZA ASSOC				$	$		$	$	$	4
5	192		1984		2,238,672	44,651	40	55,967	11,316	1,073,391	5
6											6
7											7
8											8
	Improvement Type**										
9	CONCRETE PAVING & RAILS			1984	13,495	223	20	675	452	12,289	9
10	SPRINKLER MODIFICATION			1984	2,752		25	110	110	2,030	10
11	LOBBY RENOVATION			1984	2,489		40	62	62	1,164	11
12	TERRACE RESURFACE			1984	7,600	304	15		(304)	7,600	12
13	FOYER RE-FLOORING			1984	1,835	57	20	92	35	1,660	13
14	BASEMENT RENOVATION			1985	18,061	723	40	452	(271)	8,547	14
15	NURSING STATION REMODELLING			1985	7,755	310	20	388	78	6,919	15
16	ASPHALT ROOF			1985	7,000		15			7,000	16
17	NURSE CALL SYSTEM REWIRE			1985	4,066		15			4,066	17
18	SPRINKLER MODIFICATION			1985	2,963	119	25	119		2,039	18
19	BASEMENT AWNINGS			1985	1,620	63	15	9	(54)	1,629	19
20	GRAVEL ROOF			1985	2,700		5			2,700	20
21	CEILING BASEMENT NURSING OFFICE			1985	1,200	60	20	60		1,025	21
22	ELEVATOR OVERHAUL			1985	12,800	641	20	640	(1)	10,948	22
23	VARIOUS (ELECTRIC & SPRINKLER)			1986	5,486	196	20	274	78	4,614	23
24	ELECTRIC PANEL			1988	6,000	191	20	300	109	4,240	24
25	ELECTRICAL IMPROVEMENTS			1990	1,200	38	20	60	22	738	25
26	ELEVATOR IMPROVEMENTS			1990	15,600	495	20	780	285	9,725	26
27	TUCKPOINTING & BRICKWORK			1990	12,300	391	20	615	224	7,207	27
28	LAUNDRY ROOM DUCTWORK			1990	3,000	95	20	150	55	1,770	28
29	BUILDING EXTENSION FOR OFFICE/ACT.ROOM/DR			1994	282,054	7,336	20	14,103	6,767	120,766	29
30	DRAPERY			1994	7,933		5	1,587	1,587	12,696	30
31	ROOF & PARKING LOT IMPROVEMENTS			1995	69,984	1,992	15	4,666	2,674	33,091	31
32	ENLARGE PATIENT ROOMS(TRANS TO XI-C 97 AUDIT)			1997		149	39	149		670	32
33	WINDOWS			1998	41,775	615	25	1,671	1,056	8,355	33
34	SIDING			1998	20,000	513	25	800	287	4,000	34
35	PATIENT ROOM EXHAUST SYSTEM			1998	9,720	486	20	486		2,025	35
36	ELEVATOR SAFETY DEVICES			1998	5,350	357	15	357		1,547	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING EXTENSION (1994) ALLOWED FOR 1998	1998	$ 49,866	$	20	$ 2,493	$ 2,493	$ 12,465	37
38	ROOFTOP A/C	1999	58,870	1,509	39	1,509		5,281	38
39	LIGHTING/HAND RAILS/FLOORING/DRAPES	1999	27,264	699	39	699		2,447	39
40	CARPETING / DRAPERIES	2000	5,062	885	7	723	(162)	1,808	40
41	A/C SYSTEM	2000	6,395	233	27.5	233		611	41
42	WATER LINES, VENTING & HEATING IRON RAILING	2001	5,165	188	27.5	188		305	42
43	ELEVATOR UPGRADE / FRONT OUTDOOR WALL SYSTEM	2001	89,217	3,244	27.5	3,244		5,272	43
44	CARPETING	2001	8,264	3,851	7	1,181	(2,670)	1,771	44
45	DRAPERIES	2001	7,753	2,481	7	1,108	(1,373)	1,108	45
46	WALLPAPER / CARPETTING	2002	18,309	8,056	7	1,308	(6,748)	1,308	46
47	NURSES STATION	2002	15,101	343	27.5	343		343	47
48									48
49									49
50									50
51									51
52									52
53	ADJ TO SL			16,107			(16,107)		53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,096,676	$ 97,601		$ 97,601	$	$ 1,387,170	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 360,081	$ 36,003	$ 36,003	$	5-15 YRS	$ 294,411	71
72	Current Year Purchases	21,395	766	766		10-15 YRS	766	72
73	Fully Depreciated Assets	279,548					279,548	73
74	FROM XI-B (97 AUDIT)	14,550	1,455	1,455		10 YRS	7,275	74
75	TOTALS	$ 675,574	$ 38,224	$ 38,224	$		$ 582,000	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,852,819	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 135,825	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 135,825	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,969,170	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMIN,BANKING, /	'01 LEXUS RX300	$ 815.15	$ 9,786	17
18	PURCHASING,	99 MAXIMA	342.50	2,228	18
19	MAINT,ETC	'98 MITSUBISHI	826.97	4,054	19
20	\	'98 FORD WINDSTAR VAN	290.00	2,030	20
21	TOTAL		$ 2,274.62	$ 18,098	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		3,335		3,335
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 3,335	$	$ 3,335
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,335			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			70			70	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			29,175			29,175	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				36,635		36,635	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					28,323		28,323	13
14	TOTAL			$		$ 29,245	$ 64,958		$ 94,203	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 216,093	$ 237,054	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	936,691	936,691	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	274,721	274,721	6
7	Other Prepaid Expenses	2,947	2,947	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW		146,269	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,430,452	$ 1,597,682	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		80,569	13
14	Buildings, at Historical Cost		2,232,597	14
15	Leasehold Improvements, at Historical Cost		817,766	15
16	Equipment, at Historical Cost		677,090	16
17	Accumulated Depreciation (book methods)		(3,094,979)	17
18	Deferred Charges		8,925	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): NY LIFE INSUR.CONTRACTS	91,989	91,989	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 91,989	$ 813,957	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,522,441	$ 2,411,639	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 141,018	$ 141,018	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	71,541	71,541	28
29	Short-Term Notes Payable	188,560	188,560	29
30	Accrued Salaries Payable	150,284	150,284	30
31	Accrued Taxes Payable (excluding real estate taxes)	43,396	43,396	31
32	Accrued Real Estate Taxes(Sch.IX-B)		170,200	32
33	Accrued Interest Payable			33
34	Deferred Compensation	54,574	54,574	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED INCOME	117,463	117,463	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 766,836	$ 937,036	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		273,641	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO BP ASSOC	1,258,806		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,258,806	$ 273,641	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,025,642	$ 1,210,677	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (503,201)	$ 1,200,962	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,522,441	$ 2,411,639	48

***(See instructions.)**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (200,546)	1
2	Restatements (describe):		2
3	2001 IL REPLACEMENT TAX	(21,469)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (222,015)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	473,773	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(754,959)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (281,186)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (503,201)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,491,928	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,491,928	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	86,691	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 86,691	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	9,356	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,356	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,605	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,605	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,590,580	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	817,786	31
32	Health Care	1,893,690	32
33	General Administration	1,567,422	33
	B. Capital Expense		
34	Ownership	627,793	34
	C. Ancillary Expense		
35	Special Cost Centers	102,236	35
36	Provider Participation Fee	107,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,116,807	40
41	**Income before Income Taxes (line 30 minus line 40)****	473,773	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 473,773	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,017	4,588	$ 143,086	$ 31.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,758	25,639	606,462	23.65	3
4	Licensed Practical Nurses	7,012	7,870	139,710	17.75	4
5	Nurse Aides & Orderlies	61,178	66,936	637,953	9.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,763	4,370	41,831	9.57	7
8	Rehab/Therapy Aides	240	240	6,692	27.88	8
9	Activity Director					9
10	Activity Assistants	11,622	12,318	112,117	9.10	10
11	Social Service Workers	3,127	3,556	53,225	14.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,959	2,268	36,324	16.02	14
15	Cook Helpers/Assistants	2,114	2,368	22,625	9.55	15
16	Dishwashers	13,774	15,185	124,253	8.18	16
17	Maintenance Workers	7,014	7,724	59,321	7.68	17
18	Housekeepers	16,194	17,962	148,734	8.28	18
19	Laundry	4,661	4,984	32,657	6.55	19
20	Administrator	2,080	3,118	175,772	56.37	20
21	Assistant Administrator	4,104	4,313	65,761	15.25	21
22	Other Administrative					22
23	Office Manager	2,080	2,443	41,411	16.95	23
24	Clerical	5,624	5,931	59,871	10.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,321	191,813	$ 2,507,805 *	$ 13.07	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,728	1-3	35
36	Medical Director	O	6,500	9-3	36
37	Medical Records Consultant	N	4,128	10-3	37
38	Nurse Consultant	T	3,442	10-3	38
39	Pharmacist Consultant	H	810	10-3	39
40	Physical Therapy Consultant	L	900	10a-3	40
41	Occupational Therapy Consultant	Y	44,992	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,860	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 72,360		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	184	$ 4,600	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	118	1,180	10-3	52
53	TOTAL (lines 50 - 52)	302	$ 5,780		53

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ABRAHAM SCHIFFMAN	ADMIN	0	$ 175,772
JOYCE GRODETZ	ASST ADMIN	0	16,052
IRINA IVASHYNA	ASST ADMIN	0	13,817
DEBRA PATTY	ASST ADMIN	0	33,969
PAMELA SEEFURTH	ASST ADMIN	0	1,923
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 241,533

B. Administrative - Other

Description		Amount
CHARLOTTE KOHN	MANAGEMENT FEES	$ 329,277
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 329,277

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 3,603
IL BUSINESS SYSTEMS	DATA PROCESSING	2,101
JACOBS HEALTHCARE	DATA PROCESSING	1,050
KBKB	ACCT	17,850
RICHARD PEELO	ACCT	3,030
MYRON TUSHBAI	ACCT	12,345
SIGEL LANDAU ET AL	LEGAL	8,655
ECONOCARE	PURCHASING CONSULT	4,032
PERSONNEL PLANNERS	UC CONSULTANT	810
MUTUAL OF OMAHA	DATA PROCESSING	176
MIDWEST TIME RECORDER	DATA PROCESSING	172
ADVANTAGE BENEFITS	DEFERRED COMP ADMIN	1,197
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 55,021

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,605
Unemployment Compensation Insurance	10,903
FICA Taxes	186,107
Employee Health Insurance	102,367
Employee Meals	16,352
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,356
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	12,460
CHICAGO HEAD TAX	4,296
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 360,446

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,571
Health Care Worker Background Check	514
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	75,221
TRUST/FRANCHISE/CONTRIB/ETC	50
LICENSES & PERMITS	7,666
DUES & SUBSCRIPTIONS	30
TRUST/FRANCHISE/CONTRIB/ETC	(50)
Less: Public Relations Expense	(0)
Non-allowable advertising	(18,692)
Yellow page advertising	(56,529)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,781

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	TILE REPLACEMENT	1998	$ 4,000	4	$ 1,417	$ 1,000	$ 1,000	$ 583	$	$	$	$	$
2	PAINT/DECORATING	1999	12,840	3	2,140	4,280	4,280	2,140	992				
3	PAINT/DECORATING	2000	2,746	3		458	915	915	458				
4	PAINT/DECORATING	2001	3,239	3			540	1,080	1,080	539			
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 22,825		$ 3,557	$ 5,738	$ 6,735	$ 4,718	$ 2,530	$ 539	$	$	$

Facility Name & ID Number BIRCHWOOD PLAZA # 0028696 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **107,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **16,352** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BIRCHWOOD PLAZA **#0028696** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,728	
	REPAIRS & MAINTENANCE		0	
			0	8,728
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		778	
			0	778
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		31,284	
	ELECTRICITY		49,922	
	WATER		13,070	
	CABLE TV - LOBBY		0	
			0	94,276
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,065	
	PAINTING & DECORATING		1,052	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9,142	
	ELEVATOR MAINTENANCE & REPAIR		3,240	
	OUTSIDE LABOR		100	
	EXTERMINATING SERVICE		2,700	
	FIRE SERVICE		3,844	
			0	
			0	
			0	23,143
7	**OTHER**			
	SCAVENGER		4,920	
	SECURITY SERVICE		0	4,920
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,500	6,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	5,780	
	LABORATORY & XRAY EXPENSE		2,295	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,128	
	PHARMACY CONSULTANT	XVIII B 39-2	810	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	3,442	
	DENTAL CONSULTANT		2,625	
			0	19,080
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	900	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	44,992	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	45,892
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
	CLERGY		4,796	4,796
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,860	
			0	2,860
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	3,335	3,335

Facility Name & ID Number BIRCHWOOD PLAZA **#0028696** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		75	75
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	329,277	329,277
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,422	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	49,599	
			0	55,021
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	18,692	
	EMPLOYEE WANT ADS	XIX F	2,571	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	30	
	LICENSES & PERMITS	XIX F	7,666	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	56,529	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	50	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	514	86,052
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		150	
	EQUIPMENT REPAIR & MAINTENANCE		1,114	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,680	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		33,857	
	MESSENGER SERVICE		0	
			0	38,801

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	186,107	
	UNEMPLOYMENT COMPENSATION	XIX D	10,903	
	WORKERS COMPENSATION INSURANC	XIX D	24,605	
	HOSPITALIZATION INSURANCE	XIX D	102,367	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,356	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	12,460	
	CHICAGO HEAD TAX	XIX D	4,296	344,094
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,117	1,117
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,942	2,942
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		358,489	358,489
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,430,176

BIRCHWOOD PLAZA
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	179,585
LESS SALES TAX	(872)
NET FOOD	178,713
TOTAL PATIENT CENSUS	48,127
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	144381
ADD # EMPLOYEE MEALS/DAY	40
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	14600

PATIENT MEALS	144381
ADD EMPLOYEE MEALS	14600
TOTAL MEALS/YEAR	158981
NET FOOD	178713
DIVIDE TOTAL MEALS/YEAR	158981
COST PER MEAL	1.12
TIME EMPLOYEE MEALS	14600
EMPLOYEE MEAL RECLASSIFICATION	16352

BIRCHWOOD PLAZA
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									5,470,391	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	1,893,690	344,094	378,104	45,108	394,574	1,223,328	107,880	627,793		2,507,805
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	0		0			18,098		(18,098)		
CABLE TV			0			0				
CONTRACT NURSING										5,780
INTEREST INCOME							(2,605)			
BARBER							(1,323)			
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(329,277)		329,277		
O2 INCOME										
BAD DEBTS						0	0			
DISCOUNTS LOST							0			
ANCILLARIES								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(14,025)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	1,893,690	344,094	378,104	45,108	394,574	912,149	89,927	938,972	4,996,618	2,513,585
PER FINANCIAL STATEMENTS	1,893,690	344,094	378,104	45,108	394,574	912,149	89,927	938,972	473,773	2,513,585
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									473,773	

BIRCHWOOD PLAZA - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		70,080			70080			0	70272		
CENSUS DAYS		48,127			52319			(4,192)	55057		
OCCUPANCY %		68.67%			74.66%				78.35%		
SALARIES											
TOTAL General Services	8-1	423,914	8.83%	8.81	438390	9.41%	8.38	(14,476)	418299	9.53%	7.60
Social Services	12-1	53,225	1.11%	1.11	69296	1.49%	1.32	(16,071)	88430	2.01%	1.61
TOTAL Health Care and Programs	16-1	1,741,076	36.28%	36.18	1606899	34.47%	30.71	134,177	1524312	34.71%	27.69
Clerical & General Office Expenses	21-1	101,282	2.11%	2.10	120837	2.59%	2.31	(19,555)	113993	2.60%	2.07
TOTAL General Administration	28-1	342,815	7.14%	7.12	313236	6.72%	5.99	29,579	304714	6.94%	5.53
TOTAL Operation Expense	29-1	2,507,805	52.26%	52.11	2358525	50.60%	45.08	149,280	2247325	51.18%	40.82
ADJUSTED TOTALS											
Food	2-8	162,361	3.38%	3.37	179876	3.86%	3.44	(17,515)	162757	3.71%	2.96
Heat and Other Utilities	5-8	94,276	1.96%	1.96	111313	2.39%	2.13	(17,037)	99752	2.27%	1.81
Maintenance	6-8	100,863	2.10%	2.10	113382	2.43%	2.17	(12,519)	122810	2.80%	2.23
TOTAL General Services	8-8	805,280	16.78%	16.73	863325	18.52%	16.50	(58,045)	813385	18.52%	14.77
Administrative	17-8	570,810	11.90%	11.86	556722	11.94%	10.64	14,088	547485	12.47%	9.94
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	55,021	1.15%	1.14	81647	1.75%	1.56	(26,626)	77893	1.77%	1.41
Fees, Subscriptions, Promotions	20-8	10,781	0.22%	0.22	6231	0.13%	0.12	4,550	5427	0.12%	0.10
License Fee-IDPA	Pg21	0	0.00%	0.00	200	0.00%	0.00	(200)	0	0.00%	0.00
License Fee-Other	Pg21	7,666	0.16%	0.16	0	0.00%	0.00	7,666	2660	0.06%	0.05
Clerical & General Office Expenses	21-8	145,297	3.03%	3.02	164153	3.52%	3.14	(18,856)	160947	3.67%	2.92
Employee Benefits & Payroll Taxes	22-8	360,446	7.51%	7.49	359637	7.72%	6.87	809	337125	7.68%	6.12
Payroll Taxes	Pg21	197,010	4.11%	4.09	185942	3.99%	3.55	11,068	176062	4.01%	3.20
W/C Insurance	Pg21	24,605	0.51%	0.51	28397	0.61%	0.54	(3,792)	26657	0.61%	0.48
Health Insurance	Pg21	102,367	2.13%	2.13	107973	2.32%	2.06	(5,606)	94971	2.16%	1.72
Inservice Training & Education	23-8	1,117	0.02%	0.02	1164	0.02%	0.02	(47)	1305	0.03%	0.02
Travel and Seminar	24-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Other Admin. Staff Transportation	25-8	2,942	0.06%	0.06	3482	0.07%	0.07	(540)	1920	0.04%	0.03
Insurance-Prop.Liab.Malpractice	26-8	358,489	7.47%	7.45	304799	6.54%	5.83	53,690	181230	4.13%	3.29
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
TOTAL General Administration	28-8	1,504,903	31.36%	31.27	1477835	31.71%	28.25	27,068	1313332	29.91%	23.85
TOTAL Operation Expense	29-8	4,203,873	87.61%	87.35	4120951	88.41%	78.77	82,922	3795962	86.45%	68.95
Real Estate Taxes	33-3	172,826	3.60%	3.59	135884	2.92%	2.60	36,942	189978	4.33%	3.45
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	4,798,659	100.00%	**99.71**	4661133	100.00%	**89.09**	137,526	4390966	100.00%	**79.75**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		2059938.7	42.93%	**42.80**	2096133.8	44.97%	**40.06**	(36,195)	1898052.4	43.23%	**34.47**

BIRCHWOOD PLAZA - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 4718 from Page 22 and 0 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-41567 RELATED PARTY 41567
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1. RELATED PARTY 170200
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-135825 RELATED PARTY 135825
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4. N/A-RELATED PARTY
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 DO NOT EQUAL Page 21-G. NO TRAVEL